No. 09-430

# In The Supreme Court of the United States

RAKESH WAHI,

*Petitioner*,

v.

CHARLESTON AREA MEDICAL CENTER, *et al.*,

*Respondents.*

ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

## SEALED
## BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI


Richard D. Jones
*Counsel of Record*
FLAHERTY, SENSABAUGH & BONASSO, PLLC
200 Capitol Street
Charleston, WV 25301
(304) 345-0200
rjones@fsblaw.com

David S. Givens
FLAHERTY, SENSABAUGH & BONASSO, PLLC
1225 Market Street
Wheeling, WV 26003
(304) 230-6600
davidg@fsblaw.com

*Counsel for Respondents*


*Dated: December 14, 2009*


THE LEX GROUP$^{DC}$ ♦ 1750 K Street N.W. ♦ Suite 475 ♦ Washington, DC 20006
(202) 955-0001 ♦ (800) 815-3791 ♦ Fax: (202) 955-0022 ♦www.thelexgroup.com

## QUESTION PRESENTED

1. Whether Petitioner has presented compelling reasons to grant the Petition.

## PARTIES TO PROCEEDING AND RULE 29.6 STATEMENT

Petitioner, Rakesh Wahi, was the plaintiff-appellant in the court below.

Respondents, Charleston Area Medical Center, Inc. ("CAMC"), and Glenn Crotty ("Crotty") were defendants/appellees below.

Pursuant to Supreme Court Rule 29.6, Respondent CAMC makes the following disclosures:

CAMC is a West Virginia nonstock, nonprofit corporation. As a nonstock corporation, CAMC has no owner. However, it is a subsidiary of CAMC Health System, Inc. ("CAMCHS") by virtue of its Articles of Incorporation and Bylaws naming CAMCHS as its sole Voting Member.

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## INTRODUCTION

Petitioner, Wahi, seeks review of the Fourth Circuit's unanimous decision affirming the district court's award of summary judgment to the Respondents on the question of HCQIA immunity. However, Wahi presents no "compelling reasons" for his Petition for Writ of *Certiorari* ("Petition") to be granted. *See* Sup. Ct. R. 10. In an attempt to establish compelling reasons, Wahi contends that the Fourth Circuit's April 10, 2009, Opinion ("Opinion") creates conflicts between the circuits. Wahi's arguments are flawed, and the claimed conflicts do not exist.

First, Wahi contends that the Opinion, by affirming summary judgment without "the statutorily required possibility of imminent danger," is in conflict with decisions in four other circuits. (Pet. at 1). Wahi mischaracterizes the Opinion and the cited decisions. The Opinion does not challenge the holdings of other circuits that a possibility of "imminent danger" must be present before a professional review action can enjoy immunity under § 11112(c)(2). Rather, the Opinion holds that the requirements of subsection (c)(2) need not be satisfied here because the Respondents are entitled to immunity for having complied with the reasonableness requirements of 11112(a). *Wahi v. CAMC*, 562 F.3d 599, 608 (4th Cir. 2009). Additionally, the circuit decisions cited by Wahi do not hold, as Wahi advances, that every summary suspension must be analyzed under the "imminent danger" standard of § 11112(c) as opposed to the reasonableness standards of § 11112(a), as was done

here. Thus, the Opinion creates no conflict by finding immunity under subsection (a), or by declining to apply subsection (c)(2).

Next, Wahi argues that the Opinion "deepens a pre-existing and acknowledged split involving an [sic] HCQIA plaintiff's access to a jury." (Pet. at 26). This simply is not so. The only "split" that arguably exists between the circuits regarding the "availability of jury trials" relates to who acts as the fact-finder *at trial* on the issue of immunity, judge or jury, if material disputed facts exist which preclude summary judgment.[1] Given its holding that summary judgment was correctly granted, the Opinion did not reach this issue.

Wahi's claim that the Opinion "effectively denies all HCQIA plaintiffs a jury trial" on the issue of immunity, is discredited by a simple reading of the Opinion. (Pet. at 26). The Fourth Circuit applied the same well-settled test that has been uniformly employed by the other circuits when considering whether summary judgment is warranted on the question of HCQIA immunity under § 11112(a). In applying that test, the Fourth Circuit determined that Wahi failed to present sufficient evidence to allow a reasonable jury to find that the Respondents did not provide him with fair procedures under the circumstances. The Opinion does not hold, or even suggest, that a jury trial on the issue of immunity would never be available.

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1 *See Bryan v. James E. Holmes Regional Med. Ctr.*, 33 F.3d 1318, 1332-1333 (1194) and *Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25, 33-35 (2002).

Finally, Wahi argues that this case "would be suitable for summary reversal" because "respondent [sic] concedes that it suspended Petitioner 'without a prior finding that he posed an imminent danger.'" (Pet. at 2). The Respondents make no such concession. Rather, Respondents argue, having demonstrated entitlement to immunity under § 11112(a), they need not even allege satisfaction of the "imminent danger" element of § 11112(c)(2). *Wahi*, 562 F.3d at 608. However, as the facts conclusively demonstrate that failing to suspend Wahi's medical staff privileges may have resulted in an "imminent danger" to patients, the Respondents submit that they are also entitled to summary judgment on the question of immunity under a proper § 11112(c)(2) analysis.

Wahi has failed to demonstrate compelling reasons to grant the Petition. The circuits have harmoniously applied the same legal test to the consideration of whether a defendant is entitled to HCQIA immunity as a matter of law for having complied with the reasonableness requirements of § 11112(a). That well-settled test was employed by the Fourth Circuit here. Wahi's Petition offers only a strained argument that the Fourth Circuit misapplied this test. Therefore, the Petition should be denied.

## STATEMENT OF THE CASE

### Statement of Facts

Wahi is far from the "excellent" physician portrayed in the Petition. Wahi first obtained privileges from CAMC in 1993. By early 1995, there were many and varied complaints about his practices.[2] Upon investigation, Wahi's practices were found to suffer from judgmental flaws, technical inadequacies, inadequate planning and execution, disruptive behavior and inhumane care, all of which resulted in a conclusion that he could not be entrusted with patient care. (JA 497-506), BIO 1a-14a. Those early findings led to ***Wahi's decision to voluntarily relinquish his privileges*** in January of 1996 and seek additional training, including medical ethics training. (JA 509-510).

After completing his remedial training, Wahi reapplied for privileges. (JA 511-515). On February 6, 1997, CAMC, while under no obligation to provide Wahi any privileges, granted him temporary, limited privileges to perform surgeries with restrictions: (1) precluding him from performing surgery on high-risk patients; (2) requiring him to secure from another cardiothoracic surgeon a second opinion on any

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[2] The original sources of the complaints against Wahi were not hospital administrators, members of the Medical Staff administration, or competing cardiovascular surgeons. Rather, they were the family members of patients, the anesthesiologists, scrub nurses, circulating nurses and perfusionists who worked in the operating room, the nurses and respiratory therapists in the Open Heart Recovery Unit, and the medical records personnel who gave evidence that Wahi altered permanent medical records. (JA 497-506).

proposed surgery (in the form of a written consultation made on the patient's hospital record *prior to scheduling* the surgery); and (3) requiring a proctor (another cardiothoracic surgeon) to be present for *every* surgery, from the initial incision to the last suture. (JA 516-33).

On July 16, 1998, the Chief of Staff suspended Wahi for practicing outside the scope of his privileges. (JA 517). At that time, an investigative committee reported "deep concern for Wahi's ability to deliver proper and safe medical care to patients." (JA 518, 519-22). Wahi was again suspended on April 6, 1999, for failing to obtain second opinions on multiple cases. (JA 527-31).

On February 26, 1999, Wahi submitted to the Credentials Committee an application for reappointment to the Medical Staff. The Committee initially recommended reappointment, with restrictions. (JA 532-71). Subsequently, the Committee was informed Wahi had performed another procedure outside the scope of his privileges. The Committee also learned about Wahi's relinquishment of privileges and a suspension of privileges at another hospital -- which Wahi was under duty to report, but did not. At a meeting on July 6, 1999, the Credentials Committee reconsidered its recommendation. (JA 572-73).

On July 13, 1999, the Medical Care Ombudsman Program became involved with the evaluation of whether Wahi had performed a procedure outside the scope of his privileges. (JA 574). The Ombudsman's report found that the

procedure was both outside the scope of Wahi's privileges and **unnecessary**. (JA 578-81). In another incident, Wahi "lost" a Greenfield filter in a patient, and failed to document an explanation of it on the patient's chart. (JA 582-85).[3]

At deposition, Alex Skaff, M.D., the Chief of Staff who investigated and suspended Wahi, testified that Wahi would not follow the restrictions on his privileges. In one example, Wahi performed, ". . . a high risk surgery of which it [sic] was outside the realm of the requirements [of the restrictions.]" (JA 611). In another, Wahi again scheduled a patient for surgery without a second opinion. Skaff, who is an anesthesiologist, testified that he was:

> [P]re-oping [Wahi's] patient prior to surgery, and there was no second opinion on it . . . . [a]nd I was somewhat amazed that I had just spoken with him -- I mean, this case occurred within a few weeks or whatever of me discussing specifically what those requirements -- rediscussing those requirements of which we discussed on several occasions, and in writing, that that was the requirement. And [the second opinion consult report] was not there.

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[3] A device inserted to "catch" clots and prevent them from being pumped into the lungs (pulmonary emboli). It is inserted through the jugular vein and is then deployed much like an umbrella opens. According to the Nurse Manager's Report, the Greenfield filter was "still floating around in there." (JA 584).

(JA 608). Skaff also testified that there were complaints of substandard care documented by both the Quality Improvement and Departmental Quality Assurance Committees. (JA 612-13).

Crotty, Chief Operating Officer of CAMC when Wahi was suspended on July 30, 1999, testified about Wahi's failure to abide by the restrictions on his privileges:

> [A]ny type of fences that we tried to put -- or was tried to put around him by the chief of staff and the director of medical affairs, Dr. Wahi crossed the line, and they couldn't trust him. They couldn't trust him and they had to protect the patient. Protection of the patient was the main purpose of the proctor, of the mandatory consults and the discussion that needed to occur to make sure that he wasn't working on cases that he couldn't handle. Those were his problems before.

(JA 630). Crotty described the decision of Wahi to take a high-risk patient to surgery for a lung reduction. Wahi was specifically precluded from doing lung reduction surgery, but had *characterized* the surgery as a "bullectomy," for which he was privileged. However, "[h]e was advised not to operate on patients that potentially had high-risk surgery. There was professional disagreement on whether they called this a bullectomy or a lung reduction surgery, but this patient was a high-risk patient in any regard." (JA 632-33).

Perhaps the essence of Wahi's problems was best captured by the testimony of Dr. Moritz: "The failure of Dr. Wahi to precisely comply with directives specifying the need for a proctor and written second opinions again seems to indicate that he did not respect and **in fact intended to thwart CAMC's efforts to ensure only safe and adequate care.**"

(JA 639) (emphasis added).

With this background, Skaff summarily suspended Wahi on July 30, 1999, (JA 485-86, 586-94) based upon his belief that Wahi "should not be taking care of patients." (JA 600). Skaff's decision was also based upon his determination that Wahi:

> [C]ontinued to not follow the privileges that were granted him with the restrictions over and over and over and over again. He continued to not follow the restrictions, and it was my determination on July 30th that [he] could put patients in danger. And I felt strongly about it at that time and regardless of what the Board said, regardless of what Dr. Crotty said, regardless of what Dr. Mantz said, I determined on that date that there was no question in my mind what needed to be done.

(JA 604-5).

The following events occurred in the weeks leading up to Wahi's suspension:

- By letter dated **July 16, 1999**, Skaff notified Wahi that he was investigating claims that Wahi had performed a procedure outside the scope of his privileges and also made misrepresentations in his reapplication for privileges by failing to notify CAMC of the suspension and relinquishment of his privileges at St. Francis Hospital. He requested that Wahi respond to these complaints. (JA 575-77).

- By memorandum dated **July 17, 1999**, Skaff memorialized a meeting that he had with Wahi that day. They discussed (1) Wahi's lack of written documentation regarding his change in status at both Thomas Memorial Hospital and St. Francis Hospital and (2) the "lung reduction" case. Wahi was told the case was still being investigated and that he would be informed of any developments. Wahi did not have any questions regarding either subject, but wanted to respond to both. (JA 729).

- By e-mail dated **July 18, 1999**, Wahi wrote Crotty concerning his reasons for not informing CAMC of his loss of privileges at St. Francis Hospital. (JA 730).

- By letter dated **July 23, 1999**, Wahi wrote Skaff explaining his loss of privileges at St. Francis Hospital and again attempting to justify his care of patient D.B. (JA 731).

- By report dated **July 23, 1999**, issued at the request of the Medical Care Ombudsman Program, a board-certified thoracic surgeon who had reviewed the chart of the lung reduction patient noted that the chart contained no written consultation report as required. The report further concluded that the mortality rate for this procedure in D.B. would be 10%, and that the rationale for performing the procedure was "tenuous at best." (JA 579-581).

- By letter dated **July 26, 1999**, Wahi supplemented his statement to Skaff regarding the lung reduction procedure and enclosed the patient's medical records and a letter from Dr. Joel Cooper (an expert retained by Wahi). (JA 732-41).

- By letter dated **July 28, 1999**, Dr. Mantz, Chairman of the Credentials Committee, responded to Wahi's request to postpone his August 2 appearance before the Credentials Committee. Pursuant to Wahi's request, Mantz rescheduled the Credentials Committee meeting for August 17, 1999, at 7:15 a.m. (JA 742).

- By letter dated **July 30, 1999**, Skaff advised Wahi that he was suspended "for the best interest of patient care" and cited the Procedures Manual section pertaining to his suspension. (JA 586-94).

- By memorandum dated **July 30, 1999**, Skaff memorialized the events surrounding the delivery of the July 30, 1999, letter to Wahi. Present at the meeting were Crotty, Skaff and Wahi. Wahi was informed of the reasons supporting the suspension, including his inability to follow the restrictions placed on his privileges -- and of the increasing distrust of him by the hospital and the Credentials Committee. It was recommended that he meet with the Credentials Committee and be prepared to defend his lack of adherence to the restrictions on his privileges as well as his failure to report his suspension of privileges at St. Francis Hospital. Interestingly, Wahi offered to withdraw his application for reappointment in exchange for rescinding his suspension. (JA 965).

### Brief Statement of Procedure

In the district court, Wahi asserted multiple claims, all of which were correctly addressed by the district court's order granting summary judgment. On appeal, Wahi abandoned many of his claims and focused largely on the question of HCQIA immunity. With respect to immunity, he relied primarily on the argument that summary judgment was not appropriate because no hearing had been held following his suspension. [4]

In addressing the district court's award of summary judgment on HCQIA immunity pursuant

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[4] A detailed procedural history of the case is laid out accurately in the Opinion.

to 11112(a), the Fourth Circuit noted that Wahi failed to raise any argument to support his claim that the first, second, and fourth prongs of subsection (a) were not met by the Respondents and concluded that Wahi "waived his claims" as to these subsections of the § 11112(a) HCQIA immunity test. Accordingly, the Fourth Circuit's review regarding immunity was limited to whether "the district court erred in determining that Wahi did not overcome the presumption that CAMC satisfied the requirements of subsection (a)(3)." *Wahi*, 562 F.3d at 607.

## REASONS FOR DENYING PETITION

### Brief Statement of Applicable Law

Congress enacted the Health Care Quality Improvement Act "to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior." H.R.Rep. No. 903, 99th Cong., 2d Sess. 2 (1986) *reprinted in* 1986 U.S.C.C.A.N. 6287, 6384. Congressional findings, recited in the statute, provide that "[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State," and that these problems "can be remedied through effective professional peer review." 42 U.S.C. § 11101(1), (3) (2009). To further this goal, HCQIA provides immunity from money damages in suits brought by disciplined physicians against peer review participants. 42 U.S.C. § 11111(a) (2009). The immunity is designed to facilitate frank peer

review by eliminating the fear of reprisals in civil lawsuits.

Prior to the passage of HCQIA, vigorous peer review was discouraged by the looming specter of litigation. Congress found that "[t]he threat of private money damage liability under [state and] Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review." § 11101(4). Accordingly, HCQIA provides that peer review participants meeting certain fairness requirements shall not be liable under any state or federal law for damages. § 11111(a)(1).

HCQIA also requires health care entities to report disciplinary actions to a national clearinghouse established to collect and disseminate information on health care providers. §§ 11133-34. The Act then requires a hospital to obtain a physician's records from the clearinghouse prior to granting medical staff privileges. § 11135. These reporting requirements "restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance." § 11101(2). Congress recognized that troubled physicians, now unable to hide their problems, would likely challenge peer review actions in the courts. *See* H.R. Rep. 99-903, at 3, *reprinted in* 1986 U.S.C.C.A.N. at 6385. The reporting requirements, therefore, heightened even further the need to protect peer review participants from civil damages.

For purpose of the immunity protection set forth in § 11111(a), a professional review action must be taken --

> (1) in the reasonable belief that the action was in the furtherance of quality health care,
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

§ 11112(a) (emphasis added).

Importantly, HCQIA creates a rebuttable presumption of immunity: "A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in § 11111(a) of this title *unless the presumption is rebutted by a preponderance of the evidence.*" §§ 11112(a), (a)(4) (emphasis added). Additionally, HCQIA expressly provides that "nothing in [§ 11112] shall be construed as -- precluding an immediate suspension or restriction of clinical privileges,

subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual." §§ 11112(c), (c)(2).

## Argument

### I. The Fourth Circuit's Opinion Correctly Applied Established Law and Does Not Create a Conflict with Decisions of the Third, Fifth, Eighth, and Ninth Circuits.

Wahi contends that the Opinion conflicts with four other circuits because it failed to apply a § 11112(c)(2) analysis. This argument lacks merit. The Opinion correctly holds that subsection (c) need not be addressed here because the Respondents are entitled to immunity for having complied with the reasonableness requirements of § 11112(a). *Wahi*, 562 F.3d at 614. This well-reasoned decision is consistent with the plain language and clear intent of HCQIA and does not conflict with any holding of a sister circuit.

#### A. The Possibility of "Imminent Danger" is Not Required for Entitlement to HCQIA Immunity Under § 11112(a), and the Fourth Circuit Did Not Err by Declining to Conduct a § 11112(c)(2) Analysis

As pointed out by the Fourth Circuit, the Respondents have never sought immunity under the "health emergencies" provision of § 11112(c)(2). Rather, the Respondents claim immunity for having

afforded Wahi reasonable procedures as set forth in § 11112(a)(1)-(4). Both the district court and the Fourth Circuit agreed that the Respondents satisfied the requirements of subsection (a) and, therefore, did not even consider whether immunity was proper under subsection (c)(2).

Wahi's Petition is built upon the false premise that his suspension must be treated as "immediate" within the meaning of § 11112(c)(2), having been handed down, he argues, before fair procedures were afforded him. Wahi recklessly argues that the Fourth Circuit "conceded" that he "was suspended immediately" and "held that the hospital could ignore the 'imminent danger' requirement and still obtain immunity if it *later* 'me[t] the usual standard' of providing notice and a hearing or other fair procedures." (Pet. at 1). This is a funhouse mirror reading of the Opinion, which clearly holds that fair procedures were provided to Wahi both *before* and after his suspension.

Having rewritten the Opinion, and having completely mischaracterized its reasoning, Wahi then pronounces it "indefensible" and "obviously flawed." (Pet. at 2). Wahi's indictment continues: "In other words, under the decision below, a doctor can be immediately suspended – without any 'imminent danger' – so long as the hospital provides some procedures at some point." (Pet. at 1-2). This is simply not what the Fourth Circuit held. Indeed, the Opinion expressly recognizes that "[u]nder subsection (a)(3), a health care entity seeking HCQIA immunity must act 'after adequate notice and hearing procedures are afforded to the physician

involved *or* after such other procedures as are fair to the physician under the circumstances.'" *Wahi* at 608 (citing 42 U.S.C. § 11112(a)(3)) (emphasis by italics in original, emphasis by underline added).

Wahi also ignores the Opinion's detailed discussion of the facts leading up to his July 30, 1999, suspension, including that:

- Information was received as early as July 8, 1999, that Wahi had performed a surgical procedure not permitted under the terms of his provisional privileges and that he had failed to notify CAMC, as required by the Bylaws, that he had voluntarily relinquished his privileges at another hospital. *Wahi*, 562 F.3d at 602;

- The Credentials Committee thereafter prompted an investigation into these charges. *Id.*;

- By letter dated July 16, Wahi was informed of the charges and the investigation, was asked to respond to each charge in writing as soon as possible, and was provided the relevant Bylaws pertaining to the charges. *Id.* at 603;

- Wahi apparently learned of the allegation that he had performed an unauthorized surgery prior to July 15, because on that date he wrote Crotty explaining his decision to perform the procedure and why he believed it fell within his privileges. *Id.* at 610;

- Between July 16 and July 30, Wahi met with Skaff to discuss the charges, and additional information needed to consider his responses, and wrote to the Credentials Committee Chairman to provide his side of the story. *Id.* at 603;

- Between July 16 and July 30, "Wahi wrote to Dr. Skaff and Dr. Crotty several times, addressing the charges in writing, and providing documents supporting his position that he had not violated the conditions of his clinical privileges." *Id.* at 610.

Thus, the Opinion concludes: **"The record shows that CAMC provided Wahi with notice of the most recent allegations against him, and an opportunity to respond to those allegations."** *Id.* (emphasis added). It was not until July 30, after Wahi had been provided with notice and an opportunity to respond, that his privileges were suspended for the "best interest of patient care."[5] The Fourth Circuit in no way conceded, as Wahi asserts, that he was afforded fair procedures *only after* his suspension.

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[5] The Fourth Circuit also engaged in a detailed discussion and analysis of the facts subsequent to Wahi's July 30, 1999, suspension. This was prompted at least in part by Wahi's primary argument on appeal that CAMC could not qualify for immunity because it **never** provided him with a hearing. Given that posture on appeal, the Fourth Circuit correctly looked at and considered all of the procedures and activities surrounding the July 30, 1999, suspension and determined that all of the procedures afforded, both before and after the suspension, were fair under the circumstances.

The Petition also presumes that no summary suspension can possibly satisfy the other fair procedures prong of § 11112(a)(3). No support for this position is found in HCQIA, and no court has ever held this to be so. Further, Wahi's argument is illogical. The determination of whether a peer review action is taken after fair procedures have been afforded must be based upon the facts. Because a suspension is handed down summarily does not mean that the suspension was taken without "other fair procedures" having been first afforded. The present case proves the point. It is undisputed that CAMC received complaints, investigated the complaints, and provided Wahi with notice of the complaints and an opportunity to respond before suspending him. Thus, the Fourth Circuit's holding that Wahi's suspension was taken after fair procedures had been afforded is well supported. Wahi simply ignores this clearly articulated basis for the Opinion.[6]

Having qualified for immunity under subsection (a), the question of whether Respondents also qualify for immunity under subsection (c) is of no consequence. This is precisely the reasoning the Fourth Circuit used to reach its conclusion that the "imminent danger" element of subsection (c)(2) was not implicated here:

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6 Respondents submit that the district court and Fourth Circuit had no difficulty reading and understanding the language of subsection (a)(3) – and that the Opinion clearly and correctly holds that Wahi was provided fair procedures before being suspended. Ironically, in an effort to paint the Opinion as "rewriting" HCQIA, the Petitioner decidedly rewrites the Opinion.

> Subsection (c) . . . sets out distinct ways in which a health care entity can be immune under the HCQIA without having complied with the usual requirements for claiming immunity. Wahi would have us read the statute by ignoring this clear purpose and instead find that the HCQIA immunity is barred by failing to meet one of the subsection (c) prongs. To the contrary, subsection (c) presents additional routes to HCQIA immunity beyond that set forth in subsection (a)(3).

*Wahi*, 562 F.3d at 608. This reasoning is sound, consistent with both the letter and spirit of HCQIA, and creates no conflict with the decision of another court.

### B. The Opinion Does Not Create a Conflict with the Decisions of Other Circuits

Wahi's argument that a summary suspension, by definition, cannot satisfy the "fair procedures" element of (a)(3) is unsupported by the language of HCQIA and finds no support in the case law. The courts considering immunity in this context have consistently looked to the facts to determine whether immunity is proper under subsection (a) or (c), or both. A review of the four circuit decisions Wahi *incorrectly* claims are in conflict with the Opinion illustrates the point.

### *Poliner v. Texas Health Systems*

The *Poliner* court confronted an appeal from a judgment in favor of the plaintiff, following a jury trial. The question on appeal was whether the temporary restrictions of privileges handed down during an investigation of Dr. Poliner enjoyed HCQIA immunity as a matter of law. *Poliner v. Texas Health Systems*, 537 F.3d 368, 369 (5th Cir. 2008). The *Poliner* decision reversed and rendered judgment for the defendants, holding that they were immune from money damages as a matter of law. *Id.* at 370.

Temporary restrictions were imposed on Poliner after questions were raised regarding his treatment of "Patient 36," who presented to the emergency room on May 12, 1998, suffering from a heart attack. The Chairman of the Internal Medicine Department learned of Patient 36 the next day and decided to seek a temporary restriction of Poliner's cath lab privileges to allow for an investigation. He neither conferred with nor notified Poliner before making this decision. Later the same day, the Chairman met with Poliner and presented him with the option of consenting to an abeyance of his privileges, or being suspended. This meeting was followed with a May 14 letter repeating Poliner's options, requesting his response by 5:00 p.m. that day, and informing him of how the investigation would move forward. Poliner requested more time to consult a lawyer, but this request was denied. Poliner then signed the abeyance. *Id.* at 372.

The same basic "agree or be suspended" proposition was placed before Poliner again on May 29 in the form of a letter requesting a voluntary extension of the abeyance. The letter advised Poliner that the extension was investigational in nature and that the ad hoc committee had reviewed 44 of his cases. The letter also stated that Poliner would have an opportunity to meet with the Internal Medicine Advisory Committee to respond to the ad hoc committee review. Poliner signed the extension request. *Id.* at 373.

The *Poliner* court evaluated whether the defendants were entitled to HCQIA immunity for the May 14 abeyance and the May 29 extension, which it treated as separate professional review actions. The court held that the defendants were entitled to immunity for the May 29 extension under both subsections (a) and (c) of 11112: "We conclude that the extension of the abeyance falls within section 11112(c)(2)'s curtilage, ***and in any event,* defendants imposed the restriction *after* procedures that were fair to Poliner under the circumstances**." *Id.* at 382 (emphasis added).

The *Poliner* decision continues:

> Our review . . . further leads us to conclude that the extension was imposed "after such other procedures as are fair to the physician under the circumstances." The May 14 letter provided notice to Poliner of the peer review, which patient triggered it, the other patients then-of concern, that an ad hoc Committee review would be taken and a

> general description of how that review would be conducted . . . .

*Id.* at 383. The Court also noted that "Poliner and his lawyer knew what was happening and why before the extension."[7] *Id.*

As it did with the facts before it, there can be little doubt that the *Poliner* court would have found immunity for the Respondents in the present case under subsection (a) or (c), or both:

> It is difficult to conceive of a meaningfully different response from Defendants. Upon receipt of the ad hoc committee's review, it would have been untenable to restore full privileges while a hearing was scheduled and Poliner was given time to prepare. Had Defendants immediately held a hearing, there would have been no opportunity for Poliner to review the cases at issue, and we have no doubt that we would be considering whether such a hearing was "fair."

*Id.* at 383-384. The court concludes by reiterating: "Poliner received 'fair' procedures under these

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[7] Like the Fourth Circuit in the present case, the *Poliner* court also discussed the procedures afforded to Poliner after the May 29 extension in reaching its determination of whether that professional review action enjoyed immunity. Specifically, the court pointed out that Poliner was given an opportunity to meet with the Internal Medicine Advisory Committee in person to clarify any concerns. *Id.* at 372.

circumstances." *Id.*[8] The *Poliner* decision in no way promotes Wahi's arguments.

### *Sugarbaker v. SSM Health Care*

The *Sugarbaker* decision invokes subsection (c)(2) as the primary grounds for finding that HCQIA immunity was properly granted – and, in doing so, holds the "imminent danger" requirement of subsection (c)(2) was easily satisfied. However, *Sugarbaker* also found the summary suspension justified because the hospital followed its medical staff bylaws, which permitted a precautionary suspension in the best interest of patient care, and because "the Executive Committee imposed the precautionary suspension only after the Surgery Review Committee's review of 24 of Dr. Sugarbaker's surgical cases raised concerns with respect to Dr. Sugarbaker's practice." *Sugarbaker v. SSM Health Care,* 190 F.3d 905, 917 (8th Cir. 1999). Only after these comments did the court add: "*Furthermore*, under the HCQIA's emergency provisions, summary suspensions . . . do not result in the loss of immunity 'where the failure to take such action may result in an imminent danger to the health of any

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[8] The *Poliner* decision further found: "The interplay of these provisions may work hardships on individual physicians, but the provisions reflect Congress' balancing of the significant interests of the physician and 'the public health ramifications of allowing incompetent physicians to practice while the slow wheels of justice grind.' Defendants satisfied the notice and hearing requirements, and no reasonable jury could conclude otherwise." *Poliner* at 384 (quoting *Rogers v. Columbia/HCA of Cent. La., Inc.*, 971 F. Supp. 229, 236 (W.D. La. 1997). "At the least, it is not our role to reweigh this judgment and balancing of interests by Congress." *Id.* at 385.

individual.'" *Id.* (citing 42 U.S.C. § 11112(c)(2)) (emphasis added).

A fair reading of *Sugarbaker* leads to the conclusion that the Eighth Circuit would have upheld the granting of summary judgment in the instant case under either subsection (a) or (c). Indeed, the court made it absolutely clear that it does not view HCQIA as a statute that should be strictly construed for the benefit of physicians seeking money damages:

> Even assuming arguendo that Dr. Sugarbaker has uncovered a statutory anomaly whereby various definitions contained in the HCQIA do not dovetail perfectly together, we are persuaded that Dr. Sugarbaker's selective reading of the statute cannot stand because it would undermine Congress' clear intent in enacting the statute. When the HCQIA is viewed as a whole, there is no doubt that Congress intended to improve the quality of our nation's healthcare by encouraging professional self-regulation. Accepting Dr. Sugarbaker's asserted statutory construction would seriously undermine Congress' intent . . . .

*Id.* at 917 (internal citations omitted). Nothing about the *Sugarbaker* decision conflicts with the Fourth Circuit's Opinion.

***Fobbs v. Holy Cross Health System Corp.***

Wahi's reliance on the *Fobbs* decision is puzzling. The *Fobbs* decision reinforces the Fourth Circuit's holding that immunity can be found under subsections (a) or (c). When read in conjunction with the published opinion from the United States District Court for the Eastern District of California (which it must be to make sense in the context of Wahi's Petition), the *Fobbs* decision clearly recognizes that the "other fair procedures" requirement of (a)(3) can be satisfied in a summary suspension context. *Fobbs v. Holy Cross Health Sys. Corp.*, 29 F.3d 1439 (9th Cir. 1994).

The peer review action at issue in *Fobbs* (the imposition of monitoring and consultation restraints on Fobbs' privileges to perform intra-abdominal laser surgery) was carried out without any notice or opportunity to be heard. *Fobbs v. Holy Cross Health Sys. Corp.*, 789 F.Supp. 1054, 1056 (S.D. Cal. 1992). In considering whether HCQIA immunity attached, the district court conducted an analysis under subsection (a)(1)-(4).

In its discussion of subsection (a)(3), the court notes "[p]laintiff also argues that defendants' manner of giving him notice that his privileges were restricted after the fact was not fair. In other words, he contends that, barring an emergency 'threatening imminent danger to the health of any individual,' process was due before defendants restricted his privileges." *Id.* at 1068 (emphasis added). *This is precisely Wahi's argument.* The district court disagreed: "There is no dispute that plaintiff was

given notice of the JRC [Judicial Review Committee] hearings. Therefore the question is whether or not the JRC hearings provided adequate procedure." *Id.*

The district court notes that the hospital's first two JRC proceedings were inadequate (Dr. Fobbs was not allowed to conduct voir dire of the JRC members), but places great weight on the fact that the hospital recognized this defect and agreed to provide a third hearing: "The court is satisfied that plaintiff was given the opportunity to adequate process, but that he opted not to exercise his right thereto." *Id.* Accordingly, it is clear that the district court looked at the totality of the circumstances and determined that the requirements of subsection (a)(3) were met.[9]

On appeal, the Ninth Circuit stated: "**We affirm the district court's order with the following addition to its opinion**, which affects section V.A.3. set forth on pages 1067 and 1068 relating to whether the summary monitoring restraints prior to any notice or hearing violated the HCQIA."[10] *Fobbs*, 29 F.3d 1439 at 1442 (emphasis added). The Ninth Circuit then discussed why the defendants were also entitled to immunity under subsection (c)(2), ultimately finding that "[t]he

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[9] The district court undertook a short discussion of (c)(2) as well upon defendants' argument that they were also entitled to immunity under that subsection. However, the district court's analysis was primary one of whether the procedures provided were fair given the particular circumstances.

[10] Section V.A.3.a set forth on pages 1067 and 1068 relates to the district court's discussion regarding subsection (a)(3) found on those pages.

defendants had ample medical justification to take the steps. The district court correctly granted defendants HCQIA immunity with respect to the summary monitoring restrictions." *Id.* at 1443.

Importantly, the Ninth Circuit did not overturn or in any way criticize the district court's analysis under (a)(3), or its finding that fair procedures were afforded to Fobbs under the circumstances. The Ninth Circuit likewise did not correct or criticize the fact that the district court placed great weight upon the fact that Fobbs was provided with the opportunity for an appeal hearing, but declined to avail himself of that opportunity. Therefore, the only reasonable conclusion is that the Ninth Circuit would endorse both the reasoning and ultimate finding of the Fourth Circuit in this case.

*Brader v. Allegheny General Hospital*

Nothing about the *Brader* decision suggests that the Third Circuit would have reached a different result on the question of HCQIA immunity under the facts of this case. In its "adequate notice and hearing procedures" analysis, the *Brader* court found that the district court had incorrectly concluded that questions of fact existed concerning HCQIA immunity, because the evidence, taken in a light most favorable to Brader, did not rebut that he had received ample notice and hearing procedures. The court specifically held: "For us to conclude otherwise would be to tie the hands of hospitals and force every informal review activity of a doctor or a department into time-consuming and (depending on the outcome of the informal review) possibly

unnecessary formalized proceedings." *Brader v. Allegheny General Hospital*, 167 F.3d 832, 842 (3d Cir. 1999).

Although the *Brader* court did reference § 11112(c)(2) with respect to one professional review action taken on the spot, without any warning,[11] it did not treat all pre-hearing actions taken against Dr. Brader under subsection (c). Rather, it placed considerable weight on the fact that the hospital provided advance warning to Dr. Brader regarding actions to be taken and informed him of his rights at that time, including his right to *request a hearing*.[12] In conclusion, the court held:

> that Brader has failed to rebut the presumption that AGH met the requirements for immunity under the HCQIA. He has failed to come forth with

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[11] "The one instance in which AGH did not give Brader advance warning before an adverse action was taken was when Magovern summarily suspended his AAA privileges. However, Magovern's action is covered by § 11112(c), which provides that the procedures of § 11112(a)(3) do not preclude 'an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.'" *Brader*, 167 F.3d at 842 (citing 42 U.S.C. § 11112(c)).

[12] "AGH gave Brader notice of each professional review action to be taken, informing him of his due process rights and the time in which he had to request a hearing. See § 11112(b)(1). The same day that the EC decided to recommend that Brader not be advanced to full staff and that all of his privileges be suspended, Sanzo, the Hospital president, wrote to Brader, informing him of his right to seek hearings on these recommendations." *Id.*

> sufficient evidence to allow a reasonable jury to conclude that the Hospital did not provide him with adequate and appropriate procedures, or that AGH did not act at all times in the reasonable belief that its actions would further quality health care. The grant of summary judgment to AGH will therefore be affirmed.

*Id.* at 843. The Fourth Circuit's Opinion does not conflict with the *Brader* decision.

### C. Adopting Petitioner's Proposed Statutory Framework Would Not Change the Outcome of this Case Because the Respondents Are Also Entitled to Summary Judgment on the Question of HCQIA Immunity Under § 11112(c)(2)

Wahi argues that this case would be suitable for summary reversal because Respondents concede that they suspended him without a prior finding that he posed an imminent danger. (*See* Pet. at 2, 25-26). Not so. While Respondents do argue that they qualify for immunity pursuant to § 11112(a) and need not satisfy the "imminent danger" element of subsection (c)(2) to preserve that immunity -- Respondents do <u>not</u> concede that the requirements for immunity under subsection (c)(2) were not met.

Wahi's construction of subsection (c)(2) is tortured in several respects.[13] First, nothing about the subsection requires a "finding" of imminent danger as Wahi asserts. Thus, Wahi's primary argument that immunity cannot attach because the hospital did not pronounce him an "imminent danger" before suspending him is unavailing.[14] Subsection (c)(2) requires merely that the failure to act "*may* result in an imminent danger to the health of any individual." *Brader*, 167 F.3d at 842; *Sugarbaker*, 190 F.3d at 917; *Poliner*, 537 F.3d at 383; *Fobbs*, 29 F.3d at 1442-1443. No reasonable jury could conclude that a possibility of imminent danger did not exist in this case. Moreover, even if a finding or pronouncement of imminent danger was required, the suspension of Wahi's privileges was expressly handed down "in the best interest of patient care" -- in other words, to protect patients. This may be a distinction, but there is no real difference.

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[13] Wahi's arguments, taken as a whole, attempt to turn subsection (c)(2) on its head and create an additional hurdle to immunity. Subsection (c)(2) is clearly intended to provide additional protection to the peer review actor, its purpose being to forgive contemporaneous compliance with the fair procedures requirement of (a)(3) where immediate action is needed. It is intended to expand immunity, not limit it.

[14] Wahi's factual arguments concerning the application of subsection (c)(2) are also suspect. Wahi points out that he was allowed to care for two patients still in the hospital after his suspension, but ignores that this was only for one day, and that he was not permitted to perform additional surgeries. In any event, while it may be true that Dr. Wahi's continued care of two patients for another twenty-four hours did not present a risk of imminent harm to those patients, it does not follow that failing to suspend his privileges would not have created a risk of harm *to any individual*.

It strains the patience of reasonable minds to suggest that Congress did not intend for immunity to be afforded to peer review actions taken to address lack of compliance with restrictions placed on clinical privileges under the circumstances present here. A cardiothoracic surgeon with Wahi's troubled track record, operating outside the scope of his surgical privileges, undoubtedly presents the type of danger to patients that prompted the inclusion of a provision which grants immunity for "immediate" suspensions. This is also the type of danger to the public that HCQIA immunity was generally intended to stop by fostering vigorous peer review. Therefore, Respondents are entitled to summary judgment under a proper § 11112(c)(2) analysis.

## II. THE OPINION DOES NOT DEEPEN OR WIDEN A RECOGNIZED CIRCUIT SPLIT OR CREATE A CONFLICT WITH THE FIRST AND TENTH CIRCUITS REGARDING WHETHER THE QUESTION OF HCQIA IMMUNITY CAN BE DECIDED BY A JURY

### A. The Opinion Does Not Deepen or Widen a Recognized Circuit "Split"

Wahi argues incorrectly that the Opinion "deepens a pre-existing and acknowledged split" over the availability of jury trials to determine federal immunity. (Pet. at 26). The only conflict that arguably exists between the circuits regarding the "availability of jury trials" relates to who acts as the fact-finder on the immunity issue at trial. *See Singh v. Blue Cross/BlueShield of Mass., Inc.*, 308 F.3d 25,

33-36 (1st Cir. 2002). Having found that summary judgment was correctly granted, the Fourth Circuit did not reach this issue. Accordingly, the Opinion does not "deepen" or "widen" this conflict.

### B. The Opinion Applies the Accepted Test for Summary Judgment under § 11112(a) and Does Not Establish a "No Jury" Standard

Wahi's indictment of the Opinion as effectively denying a jury trial is off the mark. The Fourth Circuit applied the well-settled summary judgment test to uphold the district court's determination that the Respondents were entitled to immunity under HCQIA. In fact, the Opinion applies precedent in the Fourth Circuit, citing to *Gabaldoni v. Washington County Hosp. Ass'n*, 250 F.3d 255, 260 (4th Cir. 2001) and *Imperial v. Suburban Hosp. Ass'n*, 37 F.3d 1026, 1030 (4th Cir. 1994) *Wahi, 562 F.3d* at 607.

Wahi argues that "[a]ccording to the Fourth Circuit, whether the procedures were 'fair * * * under the circumstances' was an exceedingly close question." (Pet. at 27). Wahi's arguments mischaracterize the Opinion and ignore the facts. While the Opinion acknowledges some arguable missteps, it makes no finding of wrongful conduct on the part of the Respondents. The opposite is true.

In considering Wahi's appeal of the district court's denial of his claims for *injunctive* relief (which are not subject to HCQIA immunity), the Fourth Circuit held that Wahi was entitled to no remedy because he had no "viable claim that CAMC

committed a wrong."[15] *Wahi*, 562 F.3d at 615. The Fourth Circuit concluded, therefore, that "Wahi has not made the requisite showing for any of the claims for which the district court determined the HCQIA immunity applied." *Id.* In short, the Fourth Circuit found that Wahi failed to demonstrate any wrongful conduct by the Respondents which would entitle him to any relief.

Wahi's claim that the Fourth Circuit found the question of whether fair procedures were afforded "exceedingly close" -- and simply "purported to break the tie" by invoking the presumption of immunity -- has no merit. Consistent with its own precedent, and the precedent of its sister circuits, the Opinion simply holds that Wahi failed to provide evidence upon which a reasonable jury could find that the procedures afforded to him were not fair under the circumstances. In doing so, it breaks no new ground, creates no conflict, and does not establish a "no jury" standard.

### C. The Opinion Does Not Create A Conflict with Decisions of the First and Tenth Circuits

In support of his claim that the Opinion wrongfully denies him a jury trial on the question of immunity and creates a conflict between the circuits, Wahi cites to *Singh* and *Brown v. Presbyterian Health Care Services*, 101 F.3d 1324 (10th Cir. 1996). These cases do not support Wahi's arguments.

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[15] Petitioner has not challenged this finding as error in his Petition, nor has he addressed it in any manner.

***Singh v. Blue Cross/Blue Shield of Mass.***

As the Fourth Circuit did here, the *Singh* Court applied the well-established summary judgment test for HCQIA immunity under § 11112(a):

> In considering the defendants' motions for summary judgment based on HCQIA immunity, we ask the following: "might a reasonable jury, viewing the facts in the best light for [Dr. Singh], conclude that he has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of *§ 11112(a)*?" *Austin, 979 F.2d at 734* (*Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 254, 91 L. Ed. 2d 202, 106 S. Ct. 2505 (1986)*); see also *Bryan, 33 F.3d at 1333* (quoting this language from Austin). Therefore, Dr. Singh can overcome HCQIA immunity at the summary judgment stage only if he demonstrates that a reasonable jury could find that the defendants did not conduct the relevant peer review actions in accordance with one of the HCQIA standards.

*Singh*, 308 F.3d at 32.

Ironically, Dr. Singh (like Wahi here) argued that the award of summary judgment wrongly denied him a jury trial regarding the reasonableness issues under HCQIA. The *Singh* court soundly rejected this argument:

> In asserting that the district court deprived him of his right to a jury trial with its summary judgment ruling, Dr. Singh overlooks the import of Congress's adoption of objective standards for the HCQIA immunity determination. Given the objective standards set forth in the statute, reasonableness determinations under the HCQIA may often become legal determinations appropriate for resolution by the judge at summary judgment. If there are no genuine disputes over material historical facts, and if the evidence of reasonableness within the meaning of the HCQIA is so one-sided that no reasonable jury could find that the defendant health care entity failed to meet the HCQIA standards, the entry of summary judgment does no violence to the plaintiff's right to a jury trial.[16]

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[16] The *Singh* Court further pointed out:

"Congress unmistakably recognized the usefulness of summary judgment proceedings in resolving immunity issues under the HCQIA prior to trial" and that:

> The Supreme Court has repeatedly emphasized that the qualified immunity determination should be made as soon as possible during the course of litigation. See *Id. at 815-16* (referring to the Court's holding in *Butz v. Economou, 438 U.S. 478, 508, 57 L. Ed. 2d 895, 98 S. Ct. 2894 (1978)*, that "insubstantial claims should not proceed to trial"). Like the Supreme Court in Harlow, Congress indicated in the legislative history of the HCQIA that its immunity determinations should also be made expeditiously. See H.R. Rep. No. 99-903, at 12, reprinted in 1986 U.S.C.C.A.N. 6384, 6394 (stating that "these provisions [are intended to]

*Id.* at 33-36.

Applying this standard, the First Circuit affirmed the district court's finding of immunity for the defendant insurer and physician auditor. The court concluded that no reasonable jury could find that the defendants failed to meet the HCQIA standards. Nothing about the *Singh* decision suggests that the First Circuit would have reached a different result in this case.

*Brown v. Presbyterian Healthcare Services*

In *Brown*, the Tenth Circuit affirmed the district court's refusal to grant judgment as a matter of law on the question of HCQIA immunity following a trial resulting in a verdict against the defendants, holding that the evidence presented a question of fact for a jury on § 11112(a)(2). *Brown*, 101 F.3d at 1327-36. The Brown decision, like all HCQIA immunity determinations, was fact-driven. Although (based upon the facts before it) the Tenth Circuit reached a different result, it applied the same well-accepted legal test for determining whether judgment as a matter of law was warranted on the question of HCQIA immunity under § 11112 (a):

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> allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible," and anticipating that courts would "determine at an early stage of litigation that the defendant has met the *[section 11112(a)]* standards").

*Singh*, 308 F.3d at 35-36.

> Thus, in determining whether a peer review participant is immune under the Health Care Quality Improvement Act, the proper inquiry . . . is whether Dr. Brown has provided sufficient evidence to permit a jury to find she has overcome, by a preponderance of the evidence, any of the four statutory elements required for immunity under 42 U.S.C. § 11112(a). See, e.g., Austin, 979 F.2d at 734.

*Id.* at 1334 n.9.

While the *Brown* decision is not directly on point -- because the *Brown* Court was looking at subsection (a)(2) (which requires "reasonable effort to obtain the facts of the matter") instead of (a)(3) -- the *Brown* court applied the same legal standards applicable generally to questions of HCQIA immunity under § 11112(a). Given a very different set of facts, it reached a different result.

Neither *Singh* nor *Brown* holds that a jury trial is *required* on the issue of immunity under HCQIA. In fact, *Singh* did not allow the question of immunity to reach a jury. It is clear under both decisions that the determination of whether summary judgment is properly granted is driven by the facts. It is also clear that summary judgment is warranted unless, as in *Brown*, the plaintiff presents sufficient evidence for a reasonable jury to find that the action taken failed to meet at least one of the statutory elements required for immunity under subsection (a). The Fourth Circuit simply found that Wahi failed to present such evidence. Thus, nothing

in the Opinion conflicts with the holdings in either *Singh* or *Brown*.

## CONCLUSION

For more than two decades, HCQIA has fostered "effective professional peer review" by providing immunity from "the threat of private money damage liability" to peer review bodies and participants who investigate and discipline troubled physicians. Having mandated in the Act that disciplined physicians be reported to a national database, Congress predicted correctly that when "faced with the certainty that they can no longer hide their past records, physicians facing disciplinary action will feel compelled to challenge vigorously any action taken against them" and file antitrust lawsuits -- *precisely as the Petitioner has done here.* H.R. Rep. 99-903, *reprinted in* 1986 U.S.C.C.A.N. at 6385. Congress further believed that those who are "sufficiently fearful of the threat of litigation will simply not do meaningful peer review," and deemed it essential, therefore, that immunity from suit be provided to peer review participants. *Id.* To this end, HCQIA provides immunity from civil damages if a professional review action meets the reasonableness standards specified in § 11112(a), and further provides a presumption that a peer review action met the standards of § 11112(a) which must be rebutted by a preponderance of the evidence. § 11111, § 11112(a)(4).

The Fourth Circuit applied the established legal test to reach its determination that Wahi failed to rebut the presumption that the Respondents were

entitled to HCQIA immunity as a matter of law pursuant to § 11112(a). The Opinion is well-reasoned and carries out the clear intent of HCQIA by protecting from civil damages those who carry out peer review. In doing so, it breaks no new ground and creates no conflict with the decision of another circuit. Accordingly, there is no compelling reason for the Petition to be granted.

Respectfully Submitted,

Richard D. Jones
*Counsel of Record*
FLAHERTY, SENSABAUGH
& BONASSO, PLLC
200 Capitol Street
Charleston, WV 25301
(304) 345-0200
rjones@fsblaw.com

David S. Givens
FLAHERTY, SENSABAUGH
& BONASSO, PLLC
1225 Market Street
Wheeling, WV 26003
(304) 230-6600
davidg@fsblaw.com

*Counsel for Respondents*

# APPENDIX

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**CONFIDENTIAL**
**EXHIBIT 14**

**Charleston Area Medical Center**

Medical Affairs Office
3200 MacCorkle Avenue, SE
Charleston, West Virginia 25304
(304) 348-4135
FAX: (304) 348-9676

December 11, 1995

Glenn Crotty, Jr., M.D.
Chief of Staff
Charleston Area Medical Center
415 Morris Street
Suite 401
Charleston, WV 25301

Dear Dr. Crotty:

This report is in response to the charge given by you to the Officers of Cardiovascular Medicine, acting as an Investigative Committee, to evaluate all components of patient care management by Dr. Rakesh Wahi at CAMC to include all past and current related issues, investigations and documentation. The general nature of the charge put before the committee included review of concerns in the following areas:

A. Clinical competence and decision making in the care and treatment of

patients and general demeanor of management.

B. Ethical standards and humanistic care.

C. Behavior disruptive of the patient care units and orderly operating of the hospital.

The committee met on seven occasions since being appointed on June 5, 1995. The investigation has been conducted in the interest of furthering the quality of patient care and in the spirit of fairness to Dr. Wahi.

In our extensive deliberations we considered the following:

1. The content and recommendations of the Special Investigative Committee's work completed March 1, 1995 and your subsequent letter of directives to Dr. Wahi (that committee interviewed two nurses, one perfusionist, seven members of the Medical Staff and Dr. Wahi).

2. The External Peer Review findings and recommendations of the American Medico-Legal Foundation and Dr. Wahi's written response to the American Medico-Legal Foundation. As you know, a delay in completing the investigative process was granted, at Dr. Wahi's request, to allow him time to prepare and submit his written comments to Drs. Gay and Ochsner.

3. Multiple Occurrence Report summaries and letters of concern or complaint from various sources.

4. Dr. Wahi's several written communications.

5. Dr. Wahi's documentation, decision making, and practice patterns of surgical and medical management were reviewed in multiple medical records.

6. The committee additionally interviewed physicians, nurses, pharmacists, administrative personnel, and physician representatives from the Medical Ethics Advisory Group and the Cardiovascular Medicine Peer Review Committee.

7. On November 22, 1995 we met with Dr. Wahi for five (5) hours and presented the major issues of concern, discussed several representative cases, heard and carefully considered his responses.

   At that time, we also presented the clinical decision, management issues and disruptive activities that precipitated the suspension of his clinical privileges on 11/6/95. We then considered his response and explanations. The committee agreed with the suspension and informed you of our recommendation that suspension should continue pending conclusion of the investigation.

## SUMMARY OF FINDINGS

A. **Clinical competence and decision making in the care and treatment of patients and general demeanor of management:**

1. External Review by American Medico-Legal Foundation: Dr. John L. Ochsner and Dr. William Gay, eminent Cardiothoracic Surgeons, reviewed 52 of Dr. Wahi's medical records for 1993-1994. While there were some discrepancies identified, when comparing Dr. Wahi's comments and American Medico-Legal Foundation case summaries with the medical records, we agree with Dr. Ochsner's and Dr. Gay's replies that none are substantial enough to appreciably impact their overall opinions and recommendations.

   The questions raised in the report regarding anesthesia management were referred to the Vice-Chief of Anesthesiology for evaluation.

   Many findings in their report were consistent with patterns identified in our internal review process and have been incorporated in the summary findings.

2. Judgement/Technical:

- He chooses and proceeds with unorthodox treatment methodologies and aggressive techniques with questionable indications and incomplete information. He quite fluently quotes literature for justification, but unfortunately **many** of the modalities, in his hands, do not achieve the authors' results. Therefore, the benefits do not outweigh the actual risks to his patients.

- In general, he does not use consultants wisely or timely and there is a pattern of ignoring consultants' advice or overriding their orders. Consultants and peers interviewed, report he is resistant to learning from experienced peer advice or example.

- He is perceived by peers/consultants and other professionals interviewed to have a false perception of patients' chances of recovery.

- There is a pattern of failure to recognize or appropriately manage low cardiac output/fluid

overload status, frequently ignoring consultant advice in this regard. Some consultants interviewed reported wishing to avoid his cases for either ethical or clinical reasons.

- There appears to be a serious flaw in Dr. Wahi's judgmental process that assumes he is able to accomplish surgical and medical management feats that other more experienced surgeons and consultants cannot.

- There have been unexpected intraoperative occurrences, eg: tear in PA during pneumonectomy, disruption of coronary sinus, obliteration of the LAD with suture, pattern of high blood transfusion requirements.

- There is a frequency of need for or reliance on IABP for sometimes questionable indications.

- His inconsistency in techniques and frequent lack of an organized plan of action in surgery impedes the smoothly functioning teamwork that is crucial in the O.R. for such complex cases as

cardiothoracic and major vascular procedures. Hostile interaction with other team members when questions/ problems follow, makes a difficult situation worse.

- There is reported hostile interaction with perfusionists when they report problems related to perfusion and difficulty in smoothly managing cardiopulmonary bypass techniques. Failure to assure adequate preop preparation or assure communication of information is detrimental to the patient's surgical care.

3. Medical Records Documentation:
Medical Records documentation, in general, is sketchy, omits important details and is inadequate to demonstrate an orderly thought process or to provide supporting rationale that justifies management choices. Several operative reports were sketchy or omitted important details of surgical procedures.

Documentation overall is inadequate to:

- Reflect adequacy and findings of pre-op work-up or patient preparation.

- Reflect indications for choice of approach or support surgical aggressiveness.

- Reflect recognition or understanding of the full scope of the patients' interrelated or core problem(s). Notes often reflect single issue focus.

This pattern of poor documentation precluded the external reviewers' and this committee's ability to substantiate many of Dr. Wahi's verbal and written retrospective claims, explanations, and justifications that are not supported by the medical record.

B. **Ethical standards and humanistic care.**

- Nurses interviewed reported several painful/protracted procedures without giving sedation/anesthesia at all, or only when nurses begged or refused to continue.

- Medical Ethics Advisory Group representatives report concerns regarding failure to honor the intent of written advance directives and patient surrogate's decisions by persisting with futile care and unreasonable expectation of patient's chances of recovery, problematic interaction with

families and instructing nurses not to discuss ethical issues with family,

- There is concern regarding lack of insight; in the majority of his verbal and written responses, Dr. Wahi blames someone else for his problems. Although there were a few valid instances duly noted by the committee, it must be recognized all the cardiothoracic surgeons work in the same system as Dr. Wahi without the preponderance of problems and complaints.

- There is a pattern of failure to avoid unnecessary suffering in his patients.

- There are violations of the Chief of Staff's written directive of 3/30/95 in regard to procedures and consideration of patient suffering:

  - On May 15, 1995, Dr. Wahi re-opened the sternum and carried out a 3 1/2 hour procedure in CVICU without anesthesia, on an awake intubated/restrained patient, in violation of a written directive from the Chief of Staff (directive #3, letter of 3/30/95). He refused to transfer the patient to the O.R., although investigation and supporting documentation indicates O.R./

Anesthesia team were available. Peer review by two cardiovascular thoracic surgeons concluded the patient should have been transferred to the O.R. after initial control established.

- Nurse witnesses reported that on 5/20/95, he attempted external cardioversion x 2, on an intubated, restrained patient in stable atrial fibrillation, before giving sedation in response to repeated nursing requests.

C. **Behavior disruptive of the patient care units and orderly operating of the hospital:**

**The following is a sampling of issues identified in interviews with, or in documented complaints from nurses, pharmacists, respiratory therapists, perfusionists, supervisors, and medical records clerks:**

- Personally changes infusion rates and ventilator settings without telling RN or RT, or documenting changes in progress notes or new orders.

- Patient care management is outside the standard of practice for other surgeons with whom they work. "His patients

just don't do well." There is loss of trust in his abilities.

- "When comes on unit, I'm afraid he's going to cause my patient pain." Doesn't give adequate sedation or pain medication.

- "His patients suffer more than other doctors' patients." "Doesn't know when to stop."

- Not receptive to questions about unusual orders.

- Gets angry when RN calls consultant labs, etc. related to the consultant's area, instead of to Dr. Wahi.

- "Experiments with his patients too much." "Does weird things."

- Doesn't communicate well with family. Doesn't give them reasonable expectations.

- Tears pages out of medical records to copy. Refuses to request copies in advance for Medical Record clerk to disassemble record and make copies. Leaves records torn apart and/or disassembled. Removes pages from Medical Records area to copy himself.

In general, Dr. Wahl creates confusion in patient care and causes diversion of resources and professional personnel from other patients and duties by frequently changing his mind, drugs and dosages, or insisting on immediate response to unorthodox requests/orders. Therefore, the focus is drawn from patients to him. There is widespread loss of confidence in his decision making and ability.

The committee concludes that Dr. Wahi's unorthodox practices and erratic communication and behavior patterns are disruptive to the orderly operations of patient care units and the hospital.

## RECOMMENDATIONS

It should be noted here that in the committee members' experience, we have always found Dr. Wahi to be interested and active in department meetings and functions, conversant with the literature and generally collegial in interactions with most of his departmental colleagues.

However, in view of the (1) documented incidents in judgmental flaws, (2) technical inadequacies, (3) lack of orderly planning and execution, (4) generally disruptive behavior, (5) widespread concerns across so many levels of professionals regarding his patient care philosophy, level of humanistic care and conduct, the committee feels Dr. Wahi cannot safely be entrusted with responsibility for patient care. Our first duty must be to the patient. Therefore, guided "by the principles of patient advocacy and the medical imperative to "first do no harm", this committee, in the interest of quality of care,

protection of future patients, and orderly operation of the hospital, makes the following recommendations:

1. Dr. Wahi not be reappointed to the Medical Staff at this time.

2. Dr. Wahi be allowed to reapply after successfully repeating a cardiothoracic residency or individualized remedial cardiothoracic training program acceptable to the Cardiovascular Medicine Department and

3. Documentation of successful completion of a Medical Ethics Course.

4. Alternatively: Dr. Wahi not be reappointed, but be allowed status of 'Clinical M.D. Assistant' to function as First Assistant Surgeon only, under the direct (line of sight) supervision of fully credentialled cardiothoracic surgeon(s), to whom the additional privilege and accountability for Dr. Wahi's activities would be granted through the Credentials process and Board of Trustees. Such a position would not include any clinical responsibilities or activity outside the confines of the surgical suite.

/s/ Jamal Khan
Jamal Khan, M.D.
Medical Director
Open Heart Recovery

/s/ K.C. Lee
K.C. Lee, M.D.
Section Chief, Thoracic
& Cardiovascular Surgery

/s/ Humayun Rashid
Humayun Rashid, M.D.
Vice Chief, Department of
Cardiovascular Medicine

/s/ Andrew Vaughan
Andrew Vaughan, M.D.
Chief, Department of
Cardiovascular Medicine